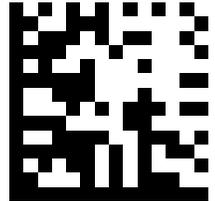


Case#: \_\_\_\_\_



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# Employer's Health Insurance Information

- This form MUST be completed by your employer or your company's Human Resources representative. Any blanks left on this form may delay the process.
- A form must be completed for each employed household member. You may copy this form.
- If you have general questions about this form or the medical programs, please call 1-866-435-7414.

## A. GENERAL INFORMATION

### Employee Information

Employee Name: \_\_\_\_\_ Employee SSN#: \_\_\_\_\_  
(first, m.i., last)

### Employer Information

Employer Name: \_\_\_\_\_  
EIN#: \_\_\_\_\_ Phone#: \_\_\_\_\_  
Address: \_\_\_\_\_  
street apt.# city state zip

### Who can we contact about employee health coverage at this job?

Contact Name: \_\_\_\_\_  
Phone#: \_\_\_\_\_ E-mail address: \_\_\_\_\_

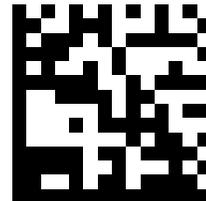
- Yes No 1. Does your company offer health insurance? If no, skip to section D. Sign and return the form.
- Yes No 2. Is your health insurance a state employee benefit plan?
- Yes No 3. Is the employee eligible to enroll in any insurance plan offered?  
If no, please explain: \_\_\_\_\_  
If yes, when is/was the employee eligible to enroll? (mm/dd/yy)\_\_\_\_\_
- Yes No 4. Is the employee or any family member enrolled in any insurance plan offered?  
If yes, name(s) of person(s) enrolled: \_\_\_\_\_
- Yes No 5. Has this employee or any family member dropped/changed coverage in the last six months?  
If yes, name(s): \_\_\_\_\_  
If yes, when did coverage end/change? (mm/dd/yy)\_\_\_\_\_
- Yes No 6. Does the employer offer a health plan that meets the \*minimum value standard?
7. For the lowest-cost plan that meets the \*minimum value standard offered only to employee (don't include family plans):  
If the employer has wellness programs, provide the premium that the employee would pay if he/she received the maximum discount for any tobacco cessation programs, and did not receive any other discounts based on the wellness programs:  
a. How much would the employee have to pay in premiums for that plan? \$\_\_\_\_\_
- b. How often? weekly every 2 weeks twice a month quarterly yearly
- Yes No 8. Do you know what change the employer will make for the new plan year? If yes, complete the following:  
Employer won't offer health insurance  
Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the \*minimum value standard.  
(Premium should not reflect the discount for wellness programs. See question 8.)  
a. How much will the employee have to pay in premiums for that plan? \$\_\_\_\_\_
- b. How often? weekly every 2 weeks twice a month quarterly yearly

\*An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60% of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

## B. EMPLOYER'S LEAST EXPENSIVE PLAN

Questions below refer to the **employer's least expensive plan**.

- Yes  No 1. Does the employee have to enroll in order to add their dependent(s)?
2. When will/did coverage begin? (mm/dd/yy) \_\_\_\_\_
3. When does the company's next open enrollment begin? (mm/dd/yy) \_\_\_\_\_
4. Complete the chart below. **Do not** include the cost of dental, vision or other coverage if it is separate.



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Monthly Premium		
	Employee's Portion	Company's Portion
Employee	\$	\$
Employee + Spouse	\$	
Employee + Child	\$	
Family	\$	

Yearly Health Plan Deductible	
Individual Amount	\$
Family Amount	\$

## C. EMPLOYEE'S HEALTH PLAN CHOICE

Questions below refer to the plan that the employee has selected. Questions 3-7 refer to "in-network" benefits.

1. Insurance company and plan name: \_\_\_\_\_
2. Policy number, if known: \_\_\_\_\_
- Yes  No 3. Is the deductible \$2,500 or less per individual?
- Yes  No 4. Is the lifetime maximum benefit \$1,000,000 or more?
- Yes  No 5. Does the plan pay at least 70% of an inpatient stay (after the deductible)?
6. What benefits are covered under this plan? (Check all that apply.)
- Physician visits     Hospital inpatient services     Pharmacy/Rx
- Yes  No 7. Does the plan cover abortion services?
- If yes, under what circumstances:
- Only in the case where the life of the mother would be endangered if the fetus were carried to term or in the case of incest or rape
- Other, please describe: \_\_\_\_\_
8. Complete this chart only if it is different from the chart in Section B. **Do not** include the cost of dental, vision or other coverage if it is separate.

Monthly Premium		
	Employee's Portion	Company's Portion
Employee	\$	\$
Employee + Spouse	\$	
Employee + Child	\$	
Family	\$	

Yearly Health Plan Deductible	
Individual Amount	\$
Family Amount	\$

- Yes  No 9. Are the employee's children currently enrolled or do they plan to enroll in your company's dental plan? If yes, name(s): \_\_\_\_\_

## D. SIGNATURE

I certify that I am a representative of the Human Resource Department, or that I am the health insurance contact person. The information on this form is true and correct to the best of my knowledge.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Name (please print): \_\_\_\_\_

Title: \_\_\_\_\_ Phone#: \_\_\_\_\_

Please return completed form to:  
 Department of Workforce Services, PO Box 143245, SLC, UT 84114-3245  
 Fax: 1-801-526-9500 Toll-Free Fax: 1-877-313-4717